Living Choices Assisted Living Waiver

Provider Application

Revised 10-08

LIVING CHOICES ASSISTED LIVING WAIVER
PROVIDER APPLICATION

As a condition for entering into or renewing a provider agreement, all applicants must complete this provider application. A true, accurate and complete disclosure of all requested information is required by the Federal and State Regulations that govern this Program. Failure of an applicant to submit the requested information or the submission of inaccurate or incomplete information may result in refusal by the Program to enter into, renew or continue a provider agreement with the applicant. Furthermore, the applicant is required by Federal and State Regulations to update the information submitted on the Provider Application.

Whenever changes in this information occur, please submit the change in writing to:

Division of Aging and Adult Services
Provider Certification Unit
P.O. Box 1437, Slot S-530
Little Rock, AR 72203-1437

All dates, except where otherwise specified, must be written in the month/day/year (MMDDYY) format. Please print all information.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
LIVING CHOICES ASSISTED LIVING WAIVER PROGRAM

PROVIDER CERTIFICATION APPLICATION

STATE OFFICE USE

Date Mailed _____ **Date Received** _____ **[ ] Initial**

Certificate # _____ **Medicaid Provider #** _____ **[ ] Renewal**

Effective Dates _____ **to** _____ **[ ] Change**

Administrative Approval _____

SECTION ONE - ALL PROVIDERS (Please type or print.)

The undersigned hereby makes application for certification by the Department of Human Services Living Choices Assisted Living Waiver Program to provide the following service: (check only one)

[ ] Assisted Living Services [ ] Pharmacy Consultant Services

_____
Name of Provider Agency Telephone #

_____
Street **and** P. O. Box (if applicable)

_____
City State Zip Code County

_____
Agency Contact Person

_____
Title Telephone #

Describe the agency's geographic service delivery area. PLEASE BE SPECIFIC.

SECTION TWO – ASSISTED LIVING SERVICES PROVIDERS

1. For an Assisted Living Facility, attach a copy of the current Long Term Care Level II Assisted Living Facility license issued by the Arkansas Division of Medical Services' Office of Long Term Care.

2. For a Home Health Agency, attach a copy of the current Home Health Agency Class A license issued by the Division of Health Facility Services, Arkansas Department of Health. Also attach a current signed copy of each contract **(financial details may be omitted)** with a licensed Level II assisted living facility to perform *Living Choices Assisted Living Waiver Program* "assisted living services".

3. Attach the original Provider Assurances signed by the Principal Official of the agency. A copy of the signed Provider Assurances should be maintained by the facility/agency.

SECTION THREE – PHARMACIST CONSULTANT PROVIDERS

1. For an individual pharmacist not affiliated with a pharmacy, attach a copy of the current pharmacist license and certification as a Consultant Pharmacist in Charge issued by the Arkansas State Board of Pharmacy. Also attach a current signed copy of each working agreement with a licensed Level II assisted living facility to perform *Living Choices Assisted Living Waiver Program* "pharmacist consultant services".

2. For a pharmacy, attach a copy of the current pharmacist license and certification as a Consultant Pharmacist in Charge issued by the Arkansas Board of Pharmacy for each pharmacist affiliated with that pharmacy who will be performing "pharmacist consultant services" through the *Living Choices Assisted Living Waiver Program*. Also attach a current signed copy of each working agreement with a licensed Level II assisted living facility to perform *Living Choices Assisted Living Waiver Program* "pharmacist consultant services".

3. Attach the original Provider Assurances signed by the Principal Official of the agency. A copy of the signed Provider Assurances should be maintained by the facility/agency.

SECTION FOUR - CERTIFICATION AND VERIFICATION

I hereby certify that statements are true to the best of my knowledge and belief. I am aware that any willful misrepresentation of any material fact contained in or added as an attachment to this Application will result in the denial of certification.

I further affirm that eligibility for certification is contingent upon the agency's compliance with any federal, state or local licensure or certification requirements for the provisions of services.

Signature of Principal Official _____

Printed or Typed Name of Principal Official _____

Title _____ Date _____

PROVIDER ASSURANCES
Between
Arkansas Department of Human Services, Division of Aging and Adult Services
And
Living Choices Assisted Living Waiver Home and Community-Based Services Provider

The following assurances are applicable to funds administered by the Arkansas Department of Human Services (DHS), Division of Aging and Adult Services, hereafter referred to as the Division, in accordance with policies developed by the Division and the Arkansas Division of Medical Services for the Living Choices Assisted Living Home & Community-Based 2176 Waiver Program, hereafter referred to as Living Choices Assisted Living Waiver Program.

The principal official of the agency applying for certification as a provider of Living Choices Assisted Living Waiver services must sign these provider assurances.

The effective period of the assurances will correspond with the Provider certification, but will not exceed a twelve (12) month period. The Provider will be held accountable for further assurances or conditions to the contract that the Division may add, as is deemed necessary.

100 General Assurances

The Provider acknowledges the primary purpose of the Living Choices Assisted Living Waiver Program is to provide alternatives to institutionalization through home and community-based services for persons 65 years of age or older or persons 21 years of age or older that are blind or disabled who meet specific medical and financial criteria.

The Provider assures the Division it is in compliance with all existing rules and regulations governing the service(s) being provided and that where state or local jurisdictions require licensure for the provision of the service(s), the agency shall hold a current license.

The Provider assures the Division it presently has no interest and shall not acquire any interest, direct or indirect that would conflict in any manner or degree with the performance of Living Choices Assisted Living Waiver service(s). The Provider further agrees that in the performance of this agreement, no persons having such interest shall be employed.

The Provider assures the Division it will comply with Title VI of the Civil Rights Act of 1964 (P. L. 88-352) and the regulations issued pursuant thereto. Further, the Provider assures it has no commitments or obligation which are inconsistent with compliance with these or other pertinent federal regulations or policies, and that any other agency, organization or party that participates in the implementation of services pursuant to this agreement shall have no such commitments or obligations.

The Provider assures the Division it has written personnel policies in compliance with applicable Federal and State laws and maintains documentation to support that these policies have been communicated to all staff.

The Provider acknowledges DHS is not responsible for any modification, construction, purchasing of equipment or supplies required for compliance with any established rules or regulations the agency must undergo in order to provide Living Choices Assisted Living Waiver services.

The Provider assures the Division it has the authority and capacity to implement and perform the program of services for which they are requesting certification.

The Provider shall not assign any interest in this agreement, and shall not transfer any interest in the same, whether by assignment or notation.

101 Safety and Protection of Clients

The Provider assures the Division it shall not solicit or coerce Living Choices Assisted Living Waiver applicants or clients. Solicitation includes, but is not limited to, verbal or written promotion of the Living Choices Assisted Living Waiver Program made in an effort to persuade an individual or his/her caregiver to apply for services. In the event the Provider is found to have solicited an individual, the Provider shall be required to submit a plan of correction and be prohibited from serving the individual. Failure to correct the solicitation practice may result in the Provider's certification being placed on probation and/or revoked. Coercion is defined as, but not limited to, any verbal or written action that serves to pressure or intimidate a Living Choices Assisted Living Waiver applicant or client for any purpose. In the event the Provider is found to have coerced a Living Choices Assisted Living Waiver applicant or client, the Provider's certification shall be placed on probation and/or revoked. Provider for these purposes includes any employee or contracted personnel of the Provider.

The Provider assures the Division all necessary safeguards and precautions have been taken to protect the health and welfare of the clients they serve.

The Provider agrees to operate and provide services in full compliance with all applicable federal, state and local standards including, but not limited to, fire, health, safety and sanitation standards prescribed by law or regulations.

The Provider agrees to comply with all state and federal regulations pertaining to the funding and delivery of the waiver services that the Provider is enrolling.

The Provider agrees to protect the human rights of a Living Choices Assisted Living Waiver client by providing services without regard to race, color, religion, sex or national origin.

The Provider agrees to provide services in an environment free from physical or mental abuse for its clients and employees.

The Provider assures the Division that conditions or circumstances which place a person, or the household of a person, in imminent danger will be brought to the attention of appropriate officials for follow-up.

The Provider acknowledges their responsibility for reporting abuse established by Arkansas Statute 5-28-1 01 et. seq. (Abuse of Adults) as follows:

> Whenever any physician, surgeon, coroner, dentist, osteopath, resident, intern, registered nurse, hospital personnel who are engaged in the administration, examination, care or treatment of persons, social worker, case manager, case worker, mental health professional, peace officer, law enforcement officer, facility administrator, employee in a facility, or employee of the Department of Human Services has reasonable cause to suspect that a resident has been subjected to conditions or circumstances which would reasonably result in abuse, he shall immediately notify the person in charge of the institution, facility, or agency or his designated agent, who shall then become responsible for making a report or cause a report to be made.

In addition to those persons and officials required to report suspected adult abuse, sexual abuse, or neglect, any other person may make a report if the person has reasonable cause to suspect that an adult has been abused or neglected.

A report for individuals residing in a long term care facility shall be made immediately to the sheriff of the county in which the facility is located and to the Office of Long Term Care.

A report of abuse, neglect or exploitation of an endangered adult residing in an assisted living facility shall be reported to the Division of Medical Services, Office of Long Term Care Arkansas (Refer to Section 507, Level II Assisted Living Facility Regulations) Adult Protective Services (APS). The APS toll free telephone number is (800) 482-8049 or (501) 682-8491.

102 Staffing

The Provider assures the Division it will employ staff, qualified by education and/or experience, to perform Living Choices Assisted Living Waiver services. Personnel records shall be maintained on all employees as a contingency of certification.

The Provider assures the Division that personnel responsible for direct service delivery will be properly trained and in compliance with all applicable licensure requirements. The Provider agrees to require personnel to participate in any appropriate training provided by, or requested by the Division. The Provider acknowledges the cost of training courses for certification and/or licensure is not reimbursable through the Division or DHS.

The Provider assures the Division that each service worker possesses the necessary skills to perform the specific services required to meet the needs of the client he/she is to serve.

The Provider assures the Division that all service workers are bonded to protect the client from loss due to misconduct or mismanagement of the client’s affairs and are covered under liability insurance.

The Provider assures the Division it will maintain adequate staffing levels to ensure timely and consistent delivery of services to all clients for whom they have accepted a Living Choices Assisted Living Waiver Plan of Care.

103 Service Delivery

The Provider agrees to render all services in accordance with the Arkansas Medicaid Living Choices Assisted Living Home & Community-Based Services Waiver Provider Manual.

The Provider agrees to comply with all policies, procedures and guidelines established by the Division.

The Provider agrees to hold the Division and the Living Choices Assisted Living Waiver client harmless and shall indemnify the Division and the Living Choices Assisted Living Waiver clients for any additional costs of alternatively accomplishing the goals of the Living Choices Assisted Living Waiver Program. The Provider accepts liability for costs or fees, not limited to theft or negligence, which the Division or the Living Choices Assisted Living Waiver client may sustain as a result of the provider's performance or lack of performance. This hold harmless clause supersedes any release of responsibility signed by a Living Choices Assisted Living Waiver client. Provider, for these purposes, includes any employee or contracted person providing Living Choices Assisted Living Waiver services under this agreement.

The Provider acknowledges they may render and pursue reimbursement for services delivered in accordance with the Plan of Care developed by the DHS Registered Nurse and signed by the client's attending physician, if required. The Provider acknowledges the DHS Registered Nurse is the only authorized individual who may adjust a Living Choices Assisted Living Waiver client's Plan of Care.

The Provider agrees to inform the DHS Registered Nurse immediately via the AAS-9511 of any change in the client's physical, mental or environmental needs the Provider observes or is made aware of that may affect the client's eligibility or would necessitate a change in the client's Plan of Care.

The Provider agrees to notify the DHS Registered Nurse in writing within one (1) week of services being terminated documenting the termination effective date and the reason(s) for termination.

104 Confidentiality

The Provider agrees to implement procedures to safeguard confidential information regarding Living Choices Assisted Living Waiver clients. The Provider assures the Division no information about or obtained from a client shall be disclosed in any form identifiable with the client without the informed consent of the client.

The Provider assures that lists of Living Choices Assisted Living Waiver clients compiled pursuant to operations under this agreement shall be used solely for the purpose of providing services, will be compiled with the informed consent of each individual on such lists and under no circumstances will be made available to any individual or organization other than the Centers for Medicaid & Medicare Services, Department of Human Services, Administration on Aging, or their respective designees.

105 Record Keeping

The Provider agrees to maintain records in accordance with standard accounting procedures and to comply with all applicable state and federal regulations.

The Provider acknowledges it must maintain all records regarding the client and the Providers participation in the Arkansas Medicaid Living Choices Assisted Living Waiver Program for a period of six years from the date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. All records must be available to authorized representatives, agents or officials of the Division, DHS, Arkansas Division of Medical Services, the State Medicaid Fraud Control Unit and the Department of Human Services.

In addition to the documentation requirements imposed on providers as a contingency of Medicaid enrollment, the Provider agrees to maintain and make available for review visit reports, employee time records and incident reports.

106 Fiscal Assurances

The Provider acknowledges that Medicaid payment received for delivered Living Choices Assisted Living Waiver services is payment in full and assures the Division it will apply no additional charges nor accept any additional payment, including donations, from a Living Choices Assisted Living Waiver client or their caregiver for those services.

The Provider agrees to submit program and financial reports to DHS and/or the Division, as required.

107 Grievance

The Provider agrees to develop and implement a written grievance procedure that complies with federal and state regulations that includes, but is not to be limited to, the following:

- A mechanism to inform clients, caregivers and employees of their right to file a complaint regarding service delivery or the Provider's employment practices with the Provider directly, the DHS Registered Nurse, the Division, the Arkansas Medicaid Program or DHS,

- An assurance that the client and/or caregiver may file a grievance or otherwise seek resolution of a complaint or concern without reprisal or disruption of service,

- A provision which allows the client and/or caregiver to file and discuss their concern with the agency administrator and/or supervisory staff, and

- An assurance that every client and/or caregiver's concern will be treated with dignity and respect.

108 Quality Controls

The Provider accepts full responsibility for the quality and number of units of services provided to a Living Choices Assisted Living Waiver client by their personnel and assures the Division appropriate management and supervision of services takes place at all times.

The Provider agrees to continually monitor client satisfaction and quality of service delivery and to report their findings to the Division every ninety days via the Quarterly Monitoring Form (AAS-9506).

The Provider assures the Division it will provide a drug-free workplace and establish a drug awareness program to inform employees of:

- the dangers of drug abuse in the workplace;
- the Provider's policy for maintaining a drug-free workplace;
- any available drug counseling, rehabilitation, and employee assistance programs; and
- the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.

The Provider agrees to require staff to attend orientation training prior to allowing the employee to deliver any Living Choices Assisted Living Waiver service(s). This orientation shall include, but not be limited to, a:

- description of the purpose and philosophy of the Living Choices Assisted Living Waiver Program;
- discussion and distribution of the provider agency’s written code of ethics;
- discussion of activities which shall and shall not be performed by the employee;
- discussion, including instructions, regarding Living Choices Assisted Living Waiver record keeping requirements;
- discussion of the importance of the Plan of Care;
- discussion of the agency’s procedure for reporting changes in the client’s condition;
- discussion, including potential legal ramifications, of the client’s right to confidentiality.

109 Reporting

The Provider agrees to notify the Division in writing of the resignation or termination of the agency's Director, Executive Officer or principal official and of any change in ownership within ten (10) working days of the action.

The Provider agrees to cooperate and assist in any efforts undertaken by DHS or the Division to evaluate the effectiveness of the program and agrees to comply with any findings and/or programmatic and accounting recommendations made either through an evaluation or audit conducted by the Department or its designee.

110 Control Policies

The Provider agrees to allow the Division the right to inspect its program sites, products, policies and procedures for the purpose of determining compliance with the terms of these assurances and any applicable laws and regulations.

111 Code of Ethics

The Provider agrees to develop, distribute and enforce a written code of ethics with each employee providing services to a Living Choices Assisted Living Waiver client that shall include, but not be limited to, the following:

- No consumption of the client's food or drink;
- No use of the client's telephone for personal calls;
- No discussion of one's personal problems, religious or political beliefs with the client;
- No acceptance of gifts or tips from the client or their caregiver;
- No friends, relatives or unauthorized individuals are to accompany the employee to client's assisted living facility apartment unit;
- No consumption of alcoholic beverages or use of non-prescribed drugs prior to service delivery nor in the client's assisted living facility apartment unit,
- No smoking in the client's assisted living facility apartment unit;
- No solicitation of money or goods from the client;
- No breech of the client's privacy or confidentiality of records.

112 Independent Assessment

The Provider agrees to participate in an independent assessment of waiver services to evaluate quality of care, access to care and cost effectiveness.

113 Responsibilities of the Division of Aging & Adult Services

The Division of Aging & Adult Services (DAAS) will be responsible for the following:

- Oversight of all state and federally funded activities that involve service delivery to Living Choices Assisted Living clients;
- Maintaining a list of all enrolled Living Choices Assisted Living waiver services providers;
- Accepting client complaints with regard to delivery of Living Choices Assisted Living waiver services. This shall include:
    1. Maintaining a file on all complaints;
    2. Investigating complaints, unless the Division determines that the complaint is without merit;
    3. Recording and filing the disposition and resolution of all complaints, indexed by provider name.

_____
Provider Name

_____ _____
Name of Principal Officer Title

_____ _____
Signature of Principal Officer Date

_____ _____
Signature of DAAS Director or Designee Date

DMS-652: Arkansas Medicaid Provider Application

Line 1:	Enter current date
Line 2:	Print your last name, first name, middle initial
Line 3:	Complete this line if you are a company
Line 4:	Circle the appropriate code
Line 5:	Enter YOUR Social Security number. If you are a company and have a Federal Tax Identification Number, please enter that number on the appropriate line.
Line 6:	Leave this line blank
Lines 7 A, B, C, D:	Enter **YOUR** street address and **YOUR** telephone number
Line 8a:	Enter the address where you want your check to be mailed. If it is the same as above – you can write SAME in this space. If you have a post office box, you may enter the box number here. **This is the address where your check will be mailed. Please make sure it is correct. You must notify DAAS in writing if this address changes or you will not receive your check.**
Line 8b:	The appropriate blank has been checked. If you have an e-mail address, complete that line.
Line 9:	Enter the County Code of the county for YOUR street address
Line 10:	Enter one of the following codes: **AH Living Choices Assisted Living Agency** **AL Living Choices Assisted Living Facility – Direct Services Provider** **AP Living Choices Assisted Living Pharmacist Consultant**
Line 14:	Fiscal Year end date will always be 12-31 (this line has been completed for you)
Lines 11-13 & 15-19:	Leave these lines blank

FOR OFFICE USE ONLY

Provider ID Number_____ Pending _____
Taxonomy Code _____
Specialty Code _____ Computer _____
Provider Type _____ OK to Key _____
Keyed _____
Effective Date_____ Maintenance Checked _____

SECTION I: ALL PROVIDERS

This section **MUST** be completed by all providers.

(1) **Date of Application:** Enter the current date in month/day/year format.
_____/_____/_____
MM DD Year

(2) **Last Name, First Name, Middle Initial, Title:** Enter the legal name of the applicant. The title spaces are reserved for designations such as MD, DDS, CRNA or OD. If the space is insufficient, please abbreviate.

If entering any other name such as an organization, corporation or facility, enter the full name of the entity in item 3. NOTE: Item 2 or 3 must be completed, <u>BUT NOT BOTH.</u>

_____ _____ _____ _____
Last Name First Name M. I. Title

(3) **Group, Organization or Facility Name:** Enter full name of the entity.
Examples: John R. Doe, PA; Adam B. Corn, Inc.; Arkansas Emer. Phys. Group; Pulaski County Hospital; John Thompson, M. D., DBA Thompson Clinic

_____
Corporation Name

_____
Fictitious Name (Doing Business As)
Must submit documentation that the above Fictitious name is registered with the appropriate board within your state, (i.e., Secretary of State's, County Clerk) of the county in which the corporation's registered office is located.

(4) **Application Type:** Circle one of the following codes which coincide with fields 2 or 3:

0 = Individual Practitioner (i.e., physician, dentist, a licensed, registered or certified practitioner)
1 = Sole Proprietorship (This includes individually owned businesses.)
2 = Government Owned
3 = Business Corporation, for profit
4 = Business Corporation, non-profit **<u>* copy of Tax Form 501 (c) (3) must accompany this application</u>**
5 = Private, for profit
6 = Private, non-profit **<u>* copy of Tax Form 501 (c) (3) must accompany this application</u>**
7 = Partnership
8 = Trust
9 = Chain

<u>* NOTE: IF THE TAX FORM IS NOT ATTACHED THE APPLICATION WILL BE DENIED</u>

(5) **SSN/FEIN Number:** Enter the Social Security Number of the applicant or the Federal Employer Identification Number of the applicant. **IF ENROLLING AN INDIVIDUAL APPLICANT THIS FIELD MUST REFLECT A SOCIAL SECURITY NUMBER.**

____- _____- _____
Social Security Number

NOTE: If an individual has a Federal Employee Identification Number, you will need to complete two (2) applications and two (2) contracts. One (1) as an individual and one (1) as an organization.

____- _____
Federal Employee Identification Number

(6) **National Provider Identification Number (NPI) and Taxonomy Code:** Enter the National Provider Identification Number and the taxonomy code of the applicant.

_____
National Provider Identification Number

_____
Taxonomy Code

(7) **Place of Service - Street Address**

(A) Enter the applicant's service location address, include suite number if applicable. THIS FIELD IS MANDATORY.

_____

(B) Enter any additional street address. (MAY REFLECT POST OFFICE BOX IF UNDELIVERABLE TO A STREET ADDRESS)

_____

(C) City, State, Zip+4 Code - enter the applicant's city, state and zip+4 code. Use the Post Office's two letter abbreviation for State. Enter the complete nine digit zip code.

_____ _____ _____
City State Zip Code+4

(D) Telephone Number - enter the area code and telephone number of the location in which the services are provided.

_____ _____
Area Code Telephone Number

(E) Fax Number – enter the area code and fax number of the location in which the services are provided.

_____ _____
Area Code Fax Number

(8a) **Billing Street Address:** This is the billing address where your Medicaid checks, Remittance Statements (RA) and information will be sent. Use the same format as the place of service address, P. O. Box may be entered in billing address.

_____

_____ _____ _____
City State Zip Code+4

_____ _____
Area Code Telephone Number

_____ _____
Area Code Fax Number

(8b) **Provider Manuals and Updates:** Please review Section I sub-section 101.000; 101 .200; 101.300 in your Arkansas Medicaid provider manual regarding provider manuals and updates. Choose the format in which you would like to receive manuals, manual updates, and official notices. The Arkansas Medicaid website (www.medicaid.state.ar.us) is updated weekly and the Arkansas Medicaid Provider Reference CD will be distributed quarterly. Providers selecting "Internet only" or "CD with e-mail notification" will receive e-mails notifying them of applicable manual updates, official notices, and remittance advice (RA) messages available at the website; these choices require an e-mail address and Internet access. Providers selecting "CD with paper supplements" will receive the Arkansas Medicaid Provider Reference CD and applicable manual updates and official notices in the mail; these providers can find RA messages with their RAs or at the Arkansas Medicaid website. Providers selecting "paper" will receive a paper copy of the manual and receive supplementary materials on paper to maintain their manual.

_____Internet only* _____ CD with e-mail notification*

_____ CD with paper supplements ___✓_____ Paper

* Selection requires an e-mail address and Internet access.

E-mail address: _____

Please make sure your e-mail address will accept e-mail from eds.com. You may need to instruct your network administrator or e-mail provider to accept e-mails from eds.com. Arkansas Medicaid sends e-mail in bulk, and some e-mail services may block bulk e-mail unless instructed otherwise.

(9) **County:** From the following list of codes, indicate the county that coincides with the place of service. If the services are provided in a bordering or out-of-state location, please use the county codes designated at the end of the code list.

County	County Code	County	County Code	County	County Code
Arkansas	01	Garland	26	Newton	51
Ashley	02	Grant	27	Ouachita	52
Baxter	03	Greene	28	Perry	53
Benton	04	Hempstead	29	Phillips	54
Boone	05	Hot Spring	30	Pike	55
Bradley	06	Howard	31	Poinsett	56
Calhoun	07	Independence	32	Polk	57
Carroll	08	Izard	33	Pope	58
Chicot	09	Jackson	34	Prairie	59
Clark	10	Jefferson	35	Pulaski	60
Clay	11	Johnson	36	Randolph	61
Cleburne	12	Lafayette	37	Saline	62
Cleveland	13	Lawrence	38	Scott	63
Columbia	14	Lee	39	Searcy	64
Conway	15	Lincoln	40	Sebastian	65
Craighead	16	Little River	41	Sevier	66
Crawford	17	Logan	42	Sharp	67
Crittenden	18	Lonoke	43	St. Francis	68
Cross	19	Madison	44	Stone	69
Dallas	20	Marion	45	Union	70
Desha	21	Miller	46	Van Buren	71
Drew	22	Mississippi	47	Washington	72
Faulkner	23	Monroe	48	White	73
Franklin	24	Montgomery	49	Woodruff	74
Fulton	25	Nevada	50	Yell	75

State	County Code	State	County Code	State	County Code
Louisiana	91	Oklahoma	94	Texas	96
Missouri	92	Tennessee	95	All other states	97
Mississippi	93				

(10) **Provider Category (A-C)**

Enter the two-digit **highlighted** code, from the following list, which identifies the services the applicant will be providing.

A) _____ B) _____ C) _____

Code	Category Description
AH	**Living Choices Assisted Living Agency**
AL	**Living Choices Assisted Living Facility - Direct Services Provider**
AP	**Living Choices Assisted Living Pharmacist Consultant**

(11) **Certification Code:** This code identifies the type of provider the certification number in field 12 defines. If an entry is made in this field (11), an entry **MUST** be made in field 12 and 13 unless the entry is a 5. Please check the appropriate code.

0 = Mental Health []
1 = Home Health []
2 = CRNA []
3 = Nursing Home []
4 = Other []
5 = Non-applicable []

(12) **Certification Number:** If applicable, enter the certification number assigned to the applicant by the appropriate certification board/agency.
A CURRENT COPY OF THIS CERTIFICATION MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

(13) **End Date:** Enter the expiration date of the applicant's current certification number in month/day/year format.

____ ____/____ ____/ ____ ____
MM DD Year

(14) **Fiscal Year:** Enter the date of the applicant's fiscal year end. This date is in month/day format.

____ ____/____ ____
MM DD

(15) **DEA Number:** If applicable, enter the number assigned to the applicant by the Federal Drug Enforcement Agency. Pharmacies must submit this information to be enrolled.
Required for Pharmacies only
A CURRENT COPY OF THIS CERTIFICATE MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____

(16) **End Date:** Enter the expiration date of the current DEA Number in month/day/year format.

____ ____/____ ____/ ____ ____

MM DD Year

(17) **License Number:** If applicable, enter the license number assigned to the applicant by the appropriate state licensure board. If the license issued is a temporary license enter **TEMP.** If the license number is smaller than the fields allowed, leave the last spaces blank.

A CURRENT COPY OF THIS LICENSE MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

(18) **End Date:** Enter the expiration date of the applicant's current license in month/day/year format.

____ ____/____ ____/ ____ ____

MM DD Year

(19) **CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA):** If applicable, enter the CLIA number assigned to the applicant. **A copy of the CLIA certificate is required in order to have your laboratory test paid.**

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Dear Provider:

Providers are encouraged to utilize **Electronic Fund Transfer** (EFT). EFT allows your Medicaid payments to be directly deposited into your bank account. You will notice a difference in your cash flow with EFT because it makes your money available sooner than the actual clearance date of paper checks. Your Medicaid Remittance Advice (RA) will continue to be mailed to the mailing address listed on your enrollment application.

If you wish to have your Medicaid payment automatically deposited, please complete the Authorization for Automatic Deposit and attach a **VOIDED CHECK OR A LETTER FROM THE BANK REFLECTING THE BANK'S ABA NUMBER AND YOUR ACCOUNT NUMBER.**

If you choose not to enroll in EFT, your checks along with your Medicaid RA will be mailed to you. **Please note that since EFT is available, checks are not available for pick-up at the EDS office.**

If you have any further questions concerning this letter, please contact the EDS Provider Assistance at (501) - 376-2211 (local or out-of-state) or 1-800-457-4454 (in-state WATS).

Sincerely,

Arkansas Department of Human Services

Authorization for Automatic Deposit

Name of Medicaid Provider _____

Provider ID # _____ Taxonomy Code _____

Provider Address _____ Telephone Number _____

City, State _____ Zip Code _____

Type of Authorization ☐ New ☐ Change ☐ Cancel

☐ Checking ☐ Savings **(if not indicated will be automatically entered as checking)**

ABA Transit Number _____ Bank Account Number _____

A COPY OF A VOIDED CHECK OR A LETTER FROM THE BANK IS REQUIRED TO VERIFY THESE NUMBERS. THE NAME ON THE VOIDED CHECK OR LETTER FROM BANK MUST MATCH THE NAME OF THE MEDICAID PROVIDER STATED ABOVE. TEMPORARY CHECKS ARE INVALID IF THEY DO NOT HAVE THE PROVIDER'S NAME AND ADDRESS PRINTED BY THE BANK.

Name of Bank _____

Bank Address _____

City, State _____ Zip Code _____

I hereby authorize the Arkansas Medicaid Program/Title XIX, to initiate credit entries to my bank account as indicated above and the depository named above to credit the same to such account. I understand I am responsible for the validity on this form.

I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws.

_____

Provider's Original Signature (required)

Please return this form to:
Medicaid Provider Enrollment Unit
EDS
P.O. Box 8105
Little Rock, AR 72203-8105

(R. 4/07)

FORM W-9

REQUEST FOR TAXPAYER

IDENTIFICATION NUMBER AND CERTIFICATION

The Department of Finance and Administration and the Department of Human Services have mandated that an IRS for W-9 be completed by all vendors doing business with the Department of Human Services.

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

CONTRACT

TO PARTICIPATE IN THE ARKANSAS MEDICAL ASSISTANCE PROGRAM ADMINISTERED BY THE DIVISION OF MEDICAL SERVICES UNDER TITLE XIX (MEDICAID)

INSTRUCTIONS

Please ensure that the provider name on the front page of the contract is identical to that listed in item #2 or item #3 of the application.

If these two names do not match, your enrollment will be denied and the enrollment packet will be returned.

CONTRACT
TO PARTICIPATE IN THE ARKANSAS MEDICAL ASSISTANCE PROGRAM
ADMINISTERED BY THE DIVISION OF MEDICAL SERVICES
TITLE XIX (MEDICAID)

The following agreement is entered into between _____, hereinafter called Provider, and the Arkansas Department of Human Services, hereafter called Department:

1. Provider, in consideration of the covenants therein, agrees:

   A. To keep records in accordance with generally accepted standards for the type of business and the healthcare services provided, related to services provided to individuals receiving assistance under the State Plan and billing for such services

   B. To make available and, upon request, furnish all records described above to the Department, the Medicaid Fraud Control Unit of the Arkansas Office of the Attorney General, the U.S. Secretary of the Department of Health and Human Services or a designated agent or representative of any entity entitled to records. For all Medicaid beneficiaries, these records include, but are not limited to those records which are defined in Section "A" of this contract. For clients who are not Medicaid beneficiaries, the records that must be furnished are financial records of charges billed to non-Medicaid insurance to ensure that charges billed to Medicaid do not exceed charges billed to non-Medicaid insurance.

      1) In connection with this contract each party hereto will receive certain confidential information relating to the other party. For purposes of this contract, any information furnished or made available to one party relating to the financial condition, results of operation, business, customers, properties, assets, liabilities or information relating to the financial condition relating to beneficiaries and providers, including but not limited to protected health information as defined by the Privacy Rule promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, is collectively referred to as “Confidential Information."

      2) The contract shall safeguard the use and disclosure of information concerning applicants for or beneficiaries of Title XIX services in accordance with 42 CFR Part 431, Subpart F, and shall comply with 45 CFR Parts 160 and 164 and shall restrict access to and disclosure of such information in compliance with federal and state laws and regulations.“

   C. To accept assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any applicable deductible or coinsurance that may be due and payable under Title XIX (Medicaid).

   D. To bill Medicaid only after a service has been provided, or as otherwise specified in the appropriate Arkansas Medicaid Provider Manual, Official Notice, or Remittance Advice message.

   E. To accept payment from Medicaid as payment in full for a covered service, and to make no additional charges to the beneficiary or accept any additional payment from the beneficiary except cost share (co-pay or deductible amounts) established by the Medicaid Program.

   F. To take assignment and file claims with third party sources (medical or liability insurance, etc.), and if third party payment is made to the Provider, to reimburse Medicaid up to the amount Medicaid paid for the services; to make no claims against third party sources for services for which a claim has been submitted to Medicaid; and to notify Medicaid of the identity of each third party source discovered after submission of a claim or claims to Medicaid.

   G. To make no charge to a beneficiary for a claim or a portion of a claim when a determination that the service was not medically necessary is made based on the professional opinion of a peer reviewer; except that such charge may be made to the beneficiary when he/she has requested the service and has prior knowledge that he/she will be responsible for the cost of such service; and to reimburse the Division of Medical Services for all monies paid for claims for services that later were determined "not medically necessary."

   H. To provide all services without discrimination on the grounds of race, color, national origin, or physical or mental disability within the provisions of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

   I. To accept all changes legally made in the Program, and recognize and abide by such changes upon being notified by the Medicaid Program in the form of an update to, or an Official Notice/Remittance Advice Message pertaining to, the appropriate Arkansas Medicaid Provider Manual.

   J. That the Department has furnished the Provider with a copy of the Arkansas Medicaid Provider Manual containing the rules, regulations and procedures pertaining to his/her profession. The Provider agrees that the terms and conditions contained therein shall be a part of this contract if the same were set out verbatim herein. The Provider states that he/she is currently licensed to practice in Arkansas or within the State where services were rendered and agrees to promptly notify the Department if his/her license is revoked or suspended. The Provider acknowledges by signature on this contract that he/she has received a copy of the appropriate Arkansas Medicaid Provider Manual.

   K. To conform to all Medicaid requirements covered in Federal or State laws, regulations or manuals.

L. To certify by original signature within 48 hours of claims being submitted by an electronic media, a claim count and dollar amount billed, that the information on the claims submitted is true, accurate and complete. The Provider agrees to maintain this certification as a matter of record for all claims submitted electronically, by any media.

M. To notify the Department before any change of ownership or operating status. Upon change of ownership or operating status the successor owner or operator shall, as a condition of assumption of this agreement, hold the Department harmless for any rate or payment increases, decreases, or adjustments without respect to whether the increase, decrease, or adjustment relates to services delivered before the change in ownership or operating status.

N. FOR HOSPITALS ONLY

To understand that the Quality Improvement Organization (Arkansas Foundation for Medical Care, Inc.) is responsible for the review of Medicaid admissions to inpatient hospitals, specifically for length of stay purposes, medical necessity and as otherwise specified in the Memorandum of Understanding between the individual hospital and Arkansas Foundation for Medical Care, Inc.

II. The Department, in consideration of the material benefits and the covenants and undertakings of the Provider, agrees as follows:

A. To make payment to the above named Provider for the appropriate Medicaid covered services provided to eligible Medicaid beneficiaries in accordance with the applicable Medicaid reimbursement schedule in effect for the dates of service, and in accordance with the manual of rules, regulations and procedures that is a part of this contract.

B. To notify the above named Provider of applicable changes in Medicaid rules and regulations as they occur.

C. To safeguard the confidentiality of any medical records received by the Department or its fiscal intermediary, as specified in Federal and State regulations.

III. This contract may be terminated or renewed in accordance with the following provisions:

A. This contract may be voluntarily terminated by either party by giving thirty (30) days written notice to the other party without cause and/or convenience of either party;

B. This contract will be automatically renewed for one year on July 1 of each year if neither party gives notice requesting termination;

C. This contract may be terminated immediately by the Department for the following reasons:
1) Returned mail
2) Death of provider
3) Change of ownership
4) Or other reason for which a sanction may be issued as set forth under the applicable Medicaid Provider Manual.

If the Provider is a legal entity other than a person, the person signing this Provider Contract on behalf of the Provider warrants that he/she has legal authority to bind the Provider. The signature of the Provider or the person with the legal authority to bind the Provider on this contract certifies the Provider understands that payment and satisfaction of these claims will be made from Federal and State funds, and that any false claims, statements, or documents, or concealment of material fact, may be prosecuted under applicable Federal and State laws.

Provider Name: _____
(As inscribed on previous page of contract)

Provider

By: _____
(Signature Required)

Name: _____
(Typed or Printed Name Required)

Title: _____
(Required)

Date: _____
(Required)

Provider Enrollment

By: _____
(Signature)

Name: _____
(Typed Name)

Title: _____

Date: _____

Effective Date of Contract: _____

Ownership and Conviction Disclosure
DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

IMPORTANT

Read ALL instructions and definitions contained on this form and use the information as a reference while completing the Ownership and Conviction Disclosure Form.

Completion and submission of this form is a condition of participation in the Medicaid Program and is a condition of approval or renewal of a provider agreement between the disclosing entity and the Division of Medical Services.

Full and accurate disclosure of ownership and financial interests is required. Failure to submit full and accurate requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements.

INSTRUCTIONS FOR COMPLETING DISCLOSURE FORM

Answer all questions as of the current date. If additional space is needed, attach the information at the end of the provider application before returning to the Medicaid Provider Enrollment Unit.

DEFINITIONS

Provider: a named person or entity that furnishes, or arranges for furnishing health related services for which it claims payment under the Medicaid Program

Disclosing entity: a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Indirect ownership: an ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership interest in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. (Example: If A owns 10% of the stock in a corporation which owns 80% of the stock of the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported).

Ownership or control interest: a person or corporation that: (1) has an ownership interest totaling 5 percent or more in a disclosing entity; (2) has an indirect ownership interest equal to 5 percent or more in a disclosing entity; (3) has a combination of direct and indirect ownership interest equal to 5 percent or more in a disclosing entity; (4) owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; (5) is an officer or director of a disclosing entity that is organized as a corporation; or (6) is a partner in a disclosing entity that is organized as a partnership.

Ownership Interest: equity in the capital, stock, or profits of the disclosing entity. To determine the percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. (Example: If A owns 10% of a note secured by 60% of the provider's assets, A's interest in the provider's assets equates to 6% and must be reported. If B owns 40% of a note secured by 10% of the provider's assets, B's interest in the provider's assets equates to 4% and need not be reported).

Managing employee: a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency

Subcontractor: (1) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of furnishing health related services; or (2) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement. Additionally, if the accrediting agency prohibits subcontracting, sub-leasing or lending its accreditation to another organization, Arkansas Medicaid will follow the restrictions set forth by the accrediting agency.

Supplier: an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier: a supplier whose total ownership interest is held by a provider or by a person/ persons or other entity with an ownership or control interest in a provider.

Significant business transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds either $25,000 or 5 percent of a provider's total operating expenses.

Ownership and Conviction Disclosure
DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Print the name, address and percentage of interest of each person, Corporation, Limited Liability Company, Partnership, Limited Liability Partnership, or other organization with a direct or indirect ownership or control interest of 5% or more in the named entity or in any subcontractor in which the named entity has direct or indirect ownership of 5% or more. [This applies to all Medicaid providers.]

Individuals – for each individual listed, provide date of birth and social security number

Name	Address	% of interest	DOB	SS#

Corporations/Limited Liability Companies/Partnerships/Other legal Entities or Organizations – for each legal entity or organization listed, provide the tax identification number and submit a copy of the legal entity or organization's IRS form SS4 and the approval letter with this application.

Name	Address	% of interest	Tax ID #

Are any of the above mentioned persons related to each other as a spouse, parent, child, or sibling? Yes_____ No_____ If yes, print name and provide relationship.

Name	Relationship

Do any of the persons, legal entities or organizations with an ownership or control interest have any ownership or control interest of 5% or more in any other entity doing business with the Arkansas Medicaid Program? Yes_____ No_____ If yes, print name and give other provider name and percentage of interest.

Name	Other Provider	% of Interest

Ownership and Conviction Disclosure
DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

List the name, address, date of birth, and social security number for any person who is a managing employee of the named entity:

Name	Address	DOB	SS#

List any person who has a direct or indirect ownership or control interest in the named entity, or is an agent, or managing employee of the named entity who has been convicted of a criminal offense related to that person's involvement in any program under Medicaid, Medicare, or Title XX programs in any state:

Name	Offense

List names of persons or entities with direct/indirect ownership or control interest in the named entity, or is an agent or managing employee of the named entity who, as listed in DHS Policy 1088 (Participant Exclusion Rule), has been found guilty, or pled guilty or nolo contendere, to any crime related to: (1) obtaining, attempting to obtain, or performing a public or private contract or subcontract, (2) embezzlement, theft, forgery, bribery, falsification or destruction of records, any form of fraud, receipt of stolen property, or any other offense indicating moral turpitude or a lack of business integrity or honesty, (3) dangerous drugs, controlled substances, or other drug-related offenses when the offense is a felony, (4) federal antitrust statutes, (5) the submission of bids or proposals, (6) any physical or sexual abuse or neglect when the offense is a felony.

Name	Offense

Ownership and Conviction Disclosure
DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Provider Statement:

"By signing this form, I certify that the information provided on this form is true and correct. I will notify the Division of Medical Services Medicaid Provider Enrollment Unit if any information changes. I will comply with all aspects of this disclosure form. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security."

Name:_____ Title:_____
(Print or Type) (Print or Type)

Signature:_____ Date:_____

Disclosure of Significant Business Transactions
DHS Division of Medical Services, Title XIX (Medicaid)
[As required by 42 C.F.R. §455, subpart B: Disclosure of Information by Providers and Fiscal Agents]

IMPORTANT

Read ALL instructions and definitions contained on this form and use the information as a reference while completing the Significant Business Transactions Disclosure Form.

Completion and submission of this form is a condition of participation in the Medicaid Program and is a condition of approval or renewal of a provider agreement between the disclosing entity and the Division of Medical Services.

Full, complete and accurate disclosure of ownership and financial interests is required. Failure to submit requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements.

INSTRUCTIONS FOR COMPLETING DISCLOSURE FORM

Answer all questions as of the current date. If additional space is needed, please attach the information at the end of the application for new enrollments, or attached to the form for updated information from existing providers, before returning to the Medicaid Provider Enrollment Unit.

DEFINITIONS

Provider: a named person or entity that furnishes, or arranges for furnishing health related services for which it claims payment under the Medicaid Program.

Disclosing entity: a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Subcontractor: (1) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of furnishing health related services; or (2) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement. Additionally, if the accrediting agency prohibits subcontracting, sub-leasing or lending its accreditation to another organization, Arkansas Medicaid will follow the restrictions set forth by the accrediting agency.

Supplier: an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier: a supplier whose total ownership interest is held by a provider or by a person/persons or other entity with an ownership or control interest in a provider.

Significant business transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds either $25,000 or 5 percent of a provider's total operating expenses.

DISCLOSURE OF SIGNIFICANT BUSINESS TRANSACTIONS

Submit full, accurate and complete disclosure concerning the following information:

1) Ownership of any subcontractor with whom the named entity has had business transactions totaling more than $25,000 during the last 12 months (12 month period ending as of the date on this application).

   _____
   _____
   _____

2) Any significant business transaction between the named entity and any wholly owned supplier in the last 5 years (5 year period ending as of the date of this application).

   _____
   _____
   _____

3) Any significant business transaction between the named entity and any subcontractor in the last 5 years (5 year period ending as of the date of this application).

   _____
   _____
   _____

Beginning on the effective date of enrollment in the Arkansas Medicaid Program, full, accurate and complete disclosure shall be submitted concerning any significant business transaction that occurs between the named entity and any subcontractor or wholly owned supplier. This information shall be submitted within 35 days of the date the transaction takes place.

Provider Statement:

"By signing this form, I certify that the information provided on this form is true and correct. I will notify the Division of Medical Services Medicaid Provider Enrollment Unit if any information changes. I will comply with all aspects of this disclosure form. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security."

Name:_____ Title:_____
(Print or Type) (Print or Type)

Signature:_____ Date:_____